

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00109931, Complaint IN00111309, and Complaint IN00111968.</p> <p>Complaint IN00109931 Substantiated, Federal/State deficiencies related to the allegations are cited at F241 and F406.</p> <p>Complaint IN00111309 Substantiated, Federal/State deficiencies related to the allegations are cited at F241, F253, and F514.</p> <p>Complaint IN00111968 Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: July 11 and 12, 2012</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 100266240</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 9 SNF/NF: 56 Total: 65</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Census payor type: Medicare: 18 Medicaid: 34 Other: 13 Total: 65</p> <p>Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/16/12 Cathy Emswiller RN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/12/2012
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to ensure call lights were answered in a timely manner, for 2 of 3 residents interviewed regarding call lights, in a sample of 7. Residents F, and G</p> <p>Findings include:</p> <p>1. On 7/11/12 at 10:55 A.M., the Administrator provided a list of residents, indicating which residents were considered interviewable. Resident F was included as interviewable.</p> <p>On 7/12/12, during confidential interview, Resident F indicated call lights were usually answered from 15 minutes to 30 minutes. Resident F indicated there was not a certain time when call lights were answered which was worse than others. Resident F indicated it took staff 2 hours at one time for a call light to be answered. Resident F indicated it was sometimes easier to just "urinate in a brief" than to wait for a call light to be answered.</p>	F0241	<p>Boonville POC</p> <p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective August 11, 2012 to the complaint survey conducted on July 11 and 12, 2012.</p> <p><b>F241</b></p> <p><b>It is the practice of Transcendent Healthcare of Boonville to always assure that residents are treated with dignity and that call lights are answered promptly</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Residents #F and #G are not specifically identified.</p> <p>However, there are systems in</p>	08/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2012
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. On 7/11/12 at 10:55 A.M., the Administrator provided a list of residents, indicating which residents were considered interviewable. Resident G was included as interviewable.</p> <p>On 7/12/12, during confidential interview, Resident G indicated she "knew when to not use her call light." Resident G indicated she knew call lights weren't answered promptly "first thing in the morning, when they are getting patients up, at mealtimes, and at bedtime when they are putting residents to bed." Resident G indicated it usually takes at least 15 minutes for her call light to be answered.</p> <p>3. On 7/12/12 at 4:00 P.M., during interview with the Director of Nursing, she indicated she would expect call lights to be answered promptly.</p> <p>This federal tag relates to Complaint IN00109931 and Complaint IN00111309.</p> <p>3.1-3(t)</p>		<p>place to assure that all residents' call lights are being answered promptly.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>The systems that are in place are meant to ensure that all residents' call lights are being answered promptly.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The facility has in-serviced all staff related to the prompt answering of call lights. If a staff member that answers the call light is non-nursing and unable to meet the resident's needs, they are to bring to the attention of nursing personnel. All nursing personnel have been in-serviced related to assuring that call lights are answered promptly and that the resident's needs are to be met at that time.</p> <p><b>The corrective action taken to monitor performance to assure compliance through</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/12/2012
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p><b>quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly interviews 5 residents that are considered interviewable to assure that their call lights are being answered promptly and that their needs are being met. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed</p> <p><b>The date the systemic changes will be completed:</b> 8-11-12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2012
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure residents' commodes and bathrooms were kept clean and sanitary, for 4 of 5 bathrooms observed on the locked unit, in a sample of 3 units. Rooms 27, 28, 29, 30</p> <p>Findings include:</p> <p>On 7/11/12 at 10:35 A.M., during the initial tour of the locked unit, an odor of urine was noted in the main hall.</p> <p>On 7/11/12 at 11:40 A.M., the following was observed:</p> <p>Room 27: bathroom floor sticky, commode soiled with grayish ring around top of commode water line Room 28: commode soiled with grayish ring around water line Room 29: bathroom floor sticky, strong urine smell Room 30: commode soiled with brownish streaks throughout the interior.</p> <p>On 7/11/12 at 2:20 P.M., the same bathrooms were observed in the same condition.</p>	F0253	<p><b>F253</b></p> <p><b>It is the practice of Transcendent Healthcare of Boonville to assure that rooms are cleaned according to the cleaning schedule.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Rooms #27, #28, #29, and #30 were thoroughly cleaned and the water stains removed from the toilet bowls prior to the survey exit.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All resident bathrooms have been reviewed, cleaned, and any hard water stains removed from toilet bowls. Please see systems below to prevent reoccurrence.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not</i></b></p>	08/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2012
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 7/11/12 at 2:30 P.M., the Administrator and Director of Nursing were shown the dirty commodes and bathrooms.</p> <p>On 7/12/12 at 10:00 A.M., during interview with the Administrator, she indicated the commodes had been scrubbed, and were now clean. The Administrator indicated the commodes were found to have hard water stains.</p> <p>On 7/12/12 at 10:40 A.M., the Alzheimer's Program Director indicated the bathrooms had been cleaned, and she suggested, "putting the rooms on a cleaning schedule."</p> <p>This federal tag relates to Complaint IN00111309.</p> <p>3.1-18(a)</p>		<p><b>recur include:</b></p> <p>All housekeeping staff has been in-serviced related to following the cleaning schedule. They have also been informed that if there are water stains that can't be removed from regular cleaning they are to notify the housekeeping supervisor so that additional interventions can be implemented.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents' rooms/bathrooms to assure they are clean and stain free. The Director of Housekeeping, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed</p> <p><b>The date the systemic changes will be completed:</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			8-11-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on interview and record review, the facility failed to ensure physical, occupational, and speech therapy evaluations were completed as ordered by the physician for 3-5 days, for 1 of 4 residents reviewed with therapy orders, in a sample of 5. Resident A</p> <p>Findings include:</p> <p>1. The clinical record of Resident A was reviewed on 7/11/12 at 12:20 P.M.</p> <p>The resident was readmitted to the facility on 7/6/12 following hospitalization for a fractured hip.</p> <p>A hospital transfer sheet, dated and signed by the physician on 7/6/12, included: "Therapy: Physical: Evaluate &amp; Treat...Occupational Therapy: Evaluate &amp; Treat, Speech: Evaluate &amp; Treat..."</p>	F0406	<p><b>F406</b></p> <p><b>It is the practice of Transcendent Healthcare of Boonville to assure therapy services are completed in a prompt manner in accordance with the physician's orders.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident A is now receiving therapy services in accordance with the physician's orders</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>Per review of our residents, all residents that have therapy</p>	08/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2012
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Therapy documentation indicated occupational and physical therapy evaluations were completed on 7/9/12.</p> <p>A speech therapy evaluation was completed on 7/11/12.</p> <p>During interview with the Therapy Manager on 7/11/12 at 1:30 P.M., she indicated, "We try to get the evals done as soon as possible." The Therapy Manager indicated she was unaware Resident A was returning on Friday 7/6/12, and she did not have any therapists scheduled for that weekend. The Therapy Manager indicated she did not have any policy in writing regarding when to get evaluations completed, but they tried to get them done as soon as possible.</p> <p>2. On 7/12/12 at 12:05 P.M., the Administrator provided the current facility policy on "Therapy Evaluations," undated. The policy included: "It is the policy of [facility] to insure that any and all physician orders received in regards to therapy evaluation and/or services will be completed within at least a 48 hour period. In the case of any unforeseen circumstances and the evaluation and/or services cannot be completed within this time frame, the physician will be contacted and an order will be written,</p>		<p>orders are receiving therapy as ordered.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The facility has reviewed its policy related to therapy services. The Therapists have been in-serviced related to the policy and assuring that therapy is initiated in a timely manner in accordance with the physician's orders. The Therapy Manager will be completing the in-service and assuring that therapy is initiated properly when orders are received.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents (if applicable) that have new orders for therapy. The sample could include new admissions, readmissions, or new orders for existing residents. The tool will review</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/12/2012
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>stating when the evaluation will be completed."</p> <p>This federal tag relates to Complaint IN00109931.</p> <p>3.1-23(a)</p>		<p>to assure that the therapy was initiated in accordance with physician's orders and the facility policy. The Rehabilitation Manager, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed</p> <p><b>The date the systemic changes will be completed:</b> 8-11-12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/12/2012
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure documentation was complete regarding readmission to the facility following a hospital stay, and residents' falls, for 2 of 4 residents reviewed for documentation, in a sample of 7. Resident A, Resident C</p> <p>Findings include:</p> <p>1. On 7/11/12 at 10:30 A.M., during the initial tour, RN # 1 indicated Resident A had recently returned to the facility following hospitalization for a fractured hip.</p> <p>The clinical record of Resident A was reviewed on 7/11/12 at 12:20 P.M.</p> <p>Nurses notes included the following notations:</p>	F0514	<p><b>F514</b> <b>It is the practice of Transcendent Healthcare of Boonville to assure resident medical records are present, organized, and stored appropriately.</b> <b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b> Resident #A and #C have been reviewed. It would not be possible to go back and assess appropriately for the incidents. Please see systems below to assist with prevention of reoccurrence.</p> <p><b><i>Other residents that have the</i></b></p>	08/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>6/21/12 at 12:40 A.M.: "See nursing assessment of a fall."</p> <p>An "Incident/Accident Documentation" form, dated 6/21/12 at 12:55 A.M., included: "...Fall [without] injury...Incident: See report pg. 1..."</p> <p>Further documentation regarding the fall was not observed in the clinical record.</p> <p>During interview with RN # 1, who indicated she had been the interim Director of Nursing [DON], on 7/11/12 at 12:30 P.M., she indicated the nurse documenting that entry was a new nurse, and probably didn't know that "Page 1 is the incident report and not part of the clinical record."</p> <p>The clinical record indicated Resident A was transferred to the hospital on 6/28/12 at 9:10 A.M.</p> <p>A hospital transfer sheet, dated 7/6/12 at 12:30 P.M., indicated the resident was transferred back to the facility on 7/6/12.</p> <p>Nurses Notes did not have a notation entered for 7/6/12. 8 blank lines were in the Nurses Notes, and then the next entry was dated 7/7/12 at 3:30 A.M. That entry indicated, "138/57, 97.7, 66, 18, 96% O2</p>		<p><b><i>potential to be affected have been identified by:</i></b></p> <p>All residents' medical records have been reviewed and for any incidents occurring in the past 7 days to assure proper documentation is present including proper assessments.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p> <p>The nurses have been in-serviced related to proper documentation including assessments of incidents and core assessments. The Interdisciplinary team will be reviewing all new admissions, readmissions, and incidents each business morning to assure that proper documentation is present. If an issue with the documentation occurs, the nurse involved will be contacted to assure that the "late entry" information is placed in the resident's medical record appropriately.</p> <p><b><i>The corrective action taken to monitor performance to</i></b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>sat [saturation] on RA [room air]. Alert to person. Able to voice wants/needs. Incontinent...Resting quietly with eyes closed."</p> <p>On 7/11/12 at 12:30 P.M., RN # 1 indicated she was unable to locate documentation of the resident's readmission to the facility. RN # 1 indicated there should have been a readmission assessment completed.</p> <p>2. The clinical record of Resident C was reviewed on 7/12/12 at 2:20 P.M.</p> <p>Nurses Notes included the following notations:</p> <p>6/23/12 at 11:10 P.M.: "Spoke [with] MD on call RT [related to] res [resident] fall @ 2300 [11:00 P.M.] RT hematoma [raised bruise] to [left] back. [Physician] gave order to apply ice to area et [and] monitor for changes to area or increased pain. Family notified...add on Fall F/U [fall up] [with] neuro checks initiated. 2355 [11:55 P.M.] Res crying out in pain @ this x [time]. Area to [left lower] back has continued to swell et starting to bruise. Rec c/o [complains of] severe pain @ this time et asked to be sent to hospital...."</p> <p>Documentation regarding the events of</p>				<p><b>assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents' medical records, if applicable, related to proper documentation/assessment of new admissions, readmissions, and incidents. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed</p> <p><b>The date the systemic changes will be completed:</b> 8-11-12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the fall was not observed in the clinical record.</p> <p>During interview with the Director of Nursing [DON] on 7/12/12 at 3:15 P.M., she indicated she was unable to find further documentation regarding the fall. The DON indicated she wondered if previous management staff who had recently left the facility had taken clinical records from the facility, including incident reports and logs. The DON indicated there should have been further documentation regarding the resident's fall.</p> <p>3. On 7/12/12 at 10:25 A.M., the Director of Nursing provided the current facility policy on "Assessments," undated. The policy included: "Purpose: To assure that each resident has accurate assessments that accurately reflect their condition. Procedure: 1. At the time of admission each resident is to have core assessments completed. These include skin, fall, hydration, and pain...If a resident returns from the hospital stay, all core assessments should be completed or updated to reflect the resident's current condition...."</p> <p>This federal tag relates to Complaint IN00111309.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-50(a)(1)			